STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	391305	A. BLDG: 00 B. WING:	07/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
TROY COMMUNITY HOSPITAL, INC. STATE LICENSE NUMBER: **460101**	**275 GUTHRIE DRIVE** **TROY, PA 16947**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 0000	INITIAL COMMENT This report is the result of a special monitoring survey. Facility attestations for the following were reviewed: New Equipment: Belmont Infuser RI-2 beginning on May 29, 2023. Event ID R73Z11. It was determined the facility was in compliance with the applicable requirements of the Pennsylvania Department of Health ' s Rules and Regulations for Hospitals, 28 Pa Code, Part IV, Subparts A and B, November 1987, as amended June 1998.	P 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Certified End Page

TROY COMMUNITY HOSPITAL, INC.

STATE LICENSE NUMBER: 460101

SURVEY EXIT DATE: 07/20/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY